Routes Healthcare (North) Limited

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Inspection report

Independence House
Holly Bank Road
Huddersfield
West Yorkshire
HD3 3LX

Tel: 01484508450

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

The inspection took place on 9 January 2019 and was announced. We also contacted staff, people using the service and their relatives by telephone to gain feedback about the service. The service was first registered on 14 December 2017 and this was their first ratings inspection.

Routes Healthcare (North) Ltd is a domiciliary care agency. It provides personal care to adults living in their own houses and flats in the community. It provides a service to older adults, younger disabled adults and children. On the day of our inspection 45 people were receiving support.

A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service had a manager in place who had applied to register with CQC, however the application had not yet been finalised.

People told us they felt safe with staff from Routes Healthcare (North) Ltd. Staff had a good understanding of how to safeguard adults from abuse.

Staff were aware of their responsibilities if they were concerned a person was at risk of harm. Care files contained detailed individual risk assessments to reduce risks to people's safety and welfare.

An electronic call monitoring system, to alert office-based staff in the event a person's call had been missed, was in place and this was monitored.

People told us staff were usually on time and were not rushed. Some people told us they would prefer more consistency of care staff, although appreciated this was not always possible. Staff recruitment was safe.

A system was in place to ensure medicines were managed in a safe way for people. Staff were trained and supported to ensure they were competent to administer medicines. A sample of medicine administration records (MARs) were audited on return to the office to enable any concerns to be addressed. A gap in auditing due to previous staff shortage had now been addressed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. We saw evidence people had given their consent to the care and support they were receiving and mental capacity assessments and best interest decisions were in place where needed.

New staff were supported in their role, which included training and shadowing a more experienced staff member. We saw evidence staff had received regular on-going training in a variety of subjects. Staff received supervision and field-based observations of their performance, although the frequency was not always in

line with the registered providers policy of four times a year. Plans were in place to address this.

People received support with meals and drinks if this was part of their care plan. Staff knew how to access relevant healthcare professionals if their input was required. The service worked in partnership with other organisations and healthcare professionals to improve people's outcomes.

People told us staff were caring and supported them in a way that maintained their dignity and privacy. People were supported to be as independent as possible throughout their daily lives.

Individual needs were assessed and met through the development of detailed personalised care plans, which considered people's equality and diversity needs and preferences.

Systems were in place to ensure complaints were encouraged, explored and responded to. People told us they knew what to do if they had any concerns or complaints about the service.

Most people told us they thought the service was well led. The registered provider had an effective system of governance in place to monitor and improve the quality and safety of the service.

People who used the service and their relatives were asked for their views about the service and these were acted on.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us they felt safe with the staff who delivered their care.

Detailed risk assessments were in place, which ensured the care and environment was safe for both people who used the service and staff.

Systems of staff recruitment were safe.

Staff were trained in medicine administration.

Is the service effective?

Good

The service was effective.

Staff supported people's right to make choices and decisions. Where people may lack mental capacity to consent, records of mental capacity assessments and best interest discussions were in place.

Staff received training, spot checks, supervision and appraisals to ensure they were able to perform their role effectively.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring.

Staff respected people's privacy and dignity.

People were encouraged to make choices and retain and improve their independence where possible.

Is the service responsive?

Good

The service was responsive.

Care was planned to meet people's individual needs and

preferences.

People and their representatives were involved in the development of their detailed support plans.

People told us they knew how to complain, and that staff were always approachable.

Is the service well-led?

Good

The service was well led.

Staff performance was regularly monitored.

The manager and the registered provider had an overview of the service.

There were systems in place to regularly seek feedback from people who used the service.

Routes Healthcare (North) Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 9 January 2019 and was announced. We gave the service 48 hours' notice of the inspection to ensure the manager would be available to meet with us. The inspection was conducted by two adult social care inspectors.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, feedback from the local authority safeguarding team and commissioners. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This information was used to help inform our inspection.

During our visit to the office we spent time looking at four people's care plans, we also looked at four records relating to staff recruitment and training, and various documents relating to the service's quality assurance systems. We spoke with the manager, the quality and safety lead, the operations manager, one care coordinator, one care assistant and one apprentice administrator in the office. We also spoke with four care assistants and six people who used the service on the telephone.

Good

Is the service safe?

Our findings

People told us they felt safe with the care provided. One person said, "I feel safe, the carers are great, and I would tell the office if I wasn't happy with anything."

Staff we spoke with understood their role in protecting people from abuse and knew how to raise concerns both within their organisation and beyond, should the need arise, to ensure people's rights were protected. We saw information around the office about reporting abuse and whistleblowing. The registered provider was also running a 'Speak out' campaign, where staff were encouraged to sign a pledge to speak out about poor staff practice, wherever it arose. This included a twenty-four-hour hot line for staff to call if concerned. This showed the registered provider was aware of their responsibility in relation to safeguarding the people they cared for.

The registered provider had an Equality and Diversity Policy which outlined staff and management duties in ensuring people were treated equally, with respect, as individuals and protected from discrimination based on the protected characteristics. This helped to keep people safe and challenge any discriminatory practice.

During this inspection we found evidence of detailed risk assessments in people's care plans. Risk assessments had been completed in relation to skin integrity, moving and handling, falls, medicines, personal care, equipment, and infection control. We saw risk assessments were in place to support both people and staff. One staff member said, "If someone was unsteady on their feet I would make sure that their walking aid was in reach and that any obstacles had been removed, such as a tripping hazard like a rug. If I thought there was an issue that presented as high risk I would inform the manager and/or family."

Each care plan we looked at contained an environment risk assessment detailing any risks relating to access, steps, fire safety, flooring and lighting and how the risk could be reduced. We saw checks on hoist slings records for two people had not been recorded in the office files. The manager sent these following the inspection, as they were kept in people's homes.

An effective system was in place to reduce the risks associated with missed calls. An electronic care visit monitoring system was in place which flagged any late or missed care visits to the office and this was then acted on by the management team. People we spoke with told us they had not had any recent missed visits. We saw the small number of missed calls had been dealt with appropriately when they arose, and action had been taken to ensure people were kept safe.

People and staff told us there were enough staff. Contingency plans were in place in the event of staff sickness and managers were on call at all times that care was being delivered. This showed the service had plans in place to enable it to respond to unexpected changes in staff availability, so the service to people using it could be maintained.

One person said, "The carers are on time and if they are going to be late they ring to tell me." A second person said, "Staff are usually on time, but when they are late I have to ring them to find out where they are."

One staff member said, "If running late I would contact my next call and let them know how late I was running, I would also contact the office and let them know." People we spoke with during this inspection did not raise any concerns that call times were shorter than planned.

The service had effective procedures in place in the event of an emergency. Staff knew what to do if they were unable to gain entry to a person's property on a planned care call, or if they found a person had fallen on the floor when they arrived at a call. One staff member said, "Most client who can't come to the door have a key safe. If a client didn't come to the door as expected I would first ring the house, if no response ring the office, family and or 999."

The registered provider was keeping an overview of the safety of the service and worked proactively to reduce risks to people. We saw from incident and accident records staff had taken appropriate action to keep people safe. The manager showed us the action they had taken in response to incidents and accidents. The quality and safety lead showed us how they used anonymous case studies of incidents to support staff and managers to reflect on and improve practice and reduce the risk of future incidents.

Safe recruitment practices had been followed. Appropriate Disclosure and Barring Service (DBS) checks and other recruitment checks were carried out as standard practice.

All staff had been trained to manage people's medicines safely and a sample of MARs were audited for any issues or concerns and these were followed up as required. Medicines records were also discussed at staff meetings. One staff member said, "I would check the care plan and if the service user self-administered I would sign the MAR sheet to say taken but not witnessed. If I administer I would take it from the blister pack and sign the MAR chart. Any missed medication would be reported to the office."

Staff were initially supported with medicines administration when shadowing more experienced staff and the registered manager told us they planned annual medicines competence assessments to ensure on-going staff competence in line with National Institute for Clinical Excellence (NICE) guidance. This meant people were protected against the risks associated with medicines because the provider had appropriate arrangements in place.

People were protected from the risks associated with infection by good staff practice. Staff told us personal protection equipment (PPE) was available to protect people from the risks of infection. People we spoke with told us staff wore gloves and aprons when providing personal care.

Good

Is the service effective?

Our findings

People we spoke with told us staff supported them well. One person said, "I don't have to tell the carers anything, they just come in and do the job."

Physical, mental health and social needs had been assessed and care plans included guidance and information to provide direction for staff and ensure care was provided in line with current good practice guidance. Assistive technology was used, when a need had been identified, and care plans gave clear direction for staff regarding its use.

Staff were provided with an induction, training, supervision and appraisal to ensure they were able to meet people's needs effectively. Staff we spoke with told us they attended the registered providers 'Excellence in care' induction training and then shadowed a staff member until they felt confident to work alone. Staff new to care completed the Care Certificate. The aim of the Care Certificate is to provide evidence that health or social care support workers have demonstrated they have the skills, knowledge and behaviours to ensure they provide compassionate and high-quality care and support.

People were supported by suitably qualified staff with the knowledge and skills to fulfil their role. We looked at the training records for four staff members and saw training included infection prevention and control (IPC), emergency first aid, food hygiene, fluid and nutrition awareness, moving and handling, equality and diversity, the MCA and DoLS, safeguarding adults, dementia awareness, end of life care and training for specific health conditions if needed. We saw training was largely up to date and further training was planned onto the rota.

Staff we spoke with told us they felt appropriately supported by managers and had regular supervision and support and an annual appraisal was currently being planned. Some supervision had not been completed in line with the registered providers policy of four times a year, although the manager was catching up. The manager was considering delegating some supervision to care coordinators now the staff team had grown. The office team also carried out regular telephone wellbeing checks with staff to see how they were, and if they had any concerns about the work they were doing. Regular supervision of staff is essential to ensure people are provided with the highest standard of care.

People were encouraged and supported with meals and drinks, to ensure they maintained a balanced diet if this type of support was required. Details of the meals eaten were recorded in people's daily records. One staff member said, "Meals are discussed with the client and prepared, where care planned. If there were any issues about nutritional intake I would raise it with the manager and/or family."

The service had good relationships with community health services and we saw the advice of professionals was included in people's care plans and used to achieve best practice and help people to achieve good outcomes.

Records showed people were supported to access external health professionals if the need arose. Staff and

the registered manager told us they would have no hesitation in contacting a person's doctor or other community health professional if the person was unwell and unable to do so themselves.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. For this type of service any applications to deprive a person of their liberty must be made to the Court of Protection (COP). No people currently using the service had a COP order in place.

The manager and staff members we spoke with had a good understanding of the Mental Capacity Act and it was clear from speaking to people that their autonomy, choices and human rights were promoted. One staff member said, "A client's capacity is recorded on the care plan and, if we need to, we work with other professionals and/or family to ensure decisions are taken in their best interest. All clients can tell you what they want and don't want to eat."

We found people had consented to their care plans where they were able to do so, and mental capacity assessments had been completed where ability to consent was in doubt. Relatives had been consulted in people's best interests were people may not have the mental capacity to make the decision. One persons updated care plan from November 2018 had not been signed and the manager told us they were awaiting this being returned from the persons home. They sent us evidence of this following our inspection.

Good

Is the service caring?

Our findings

People who used the service spoke positively about the staff and their caring attitude. One person told us they enjoyed the care staff visits and had a good relationship with them. They said, "The carers are wonderful." A second person said, "I get the same carers, they are all very nice, and we can have a laugh together."

Staff told us they enjoyed working with people who used the service. One staff member said, "The best thing is working with the clients. It gives that satisfaction. Making their day a little easier."

All the staff spoke to us about the people they supported in a caring, respectful manner and it was clear they knew people well. This included the manager and office staff. Staff could tell us how they supported people, including their personal likes and preferences.

The manager told us people were asked if they had a preference regarding the gender of the staff who provided their care as part of the initial assessment. This was recorded in the care plans we looked at and these personal preferences were respected, where possible.

People told us their privacy and dignity were respected by staff members. The members of staff we spoke with were aware of how to promote the dignity and privacy of people who used the service. One staff member said, "Keep the person as covered up as you can during personal care." A second staff member said, "Privacy and dignity would ensure clients are addressed by the name they want and would ensure they were kept covered during personal care. I would not discuss clients with other clients."

We saw people's confidential information was securely stored and people's private information was respected. Care plans were kept in a locked cabinet and staff were aware of the need to maintain confidentiality. One staff member said, "I don't talk about clients with anyone except the manager or the client themselves."

People's diverse needs were catered for and equality was promoted within the service. The manager told us they employed an ethnically diverse team and staff knew how to support the cultural needs of people from different ethnic and religious backgrounds.

People who used the service had been consulted about the care provided for them. People told us they made decisions about their care and were involved in planning their own support. We saw from care records this was the case.

The service had an enabling ethos which tried to encourage and promote people's independence. People told us they were supported to remain as independent as possible in their daily lives and we saw from records they were encouraged to do what they could for themselves.

Staff were aware of how to access advocacy services for people if the need arose. An advocate is a person

who can speak on a person's behalf, when they may not be able to do so for themselves.

Good

Is the service responsive?

Our findings

Through speaking with people and staff we felt confident people's views were taken into account and they were involved in planning their care. People told us they had a care plan in their home.

The registered manager told us when they took on a new client, a member of the management team arranged to go and meet the person. They explained this enabled them to gather the information, along with the documentation they received from other health care professionals, to develop peoples care plan and risk assessments. Care staff said if any amendments were needed to the care plan they fed this back to the office staff who made the necessary changes. This helped to ensure care plans were fully reflective of people's needs.

Staff told us they had chance to read people's care plans before delivering care. Care plans included personal information, such as the name the person liked to be known as and details of people's preferences such as how they liked to take their tea or coffee. This is important as some people who used the service had memory impairment and were not always able to communicate their preferences.

The staff we spoke with had a good awareness of the support needs and preferences of people who used the service. One staff member said, "I have a regular route, which allows me to get to know the clients, which makes the job easier." A second staff member told us they had worked the same route for nine months and built up a rapport with people.

Most people told us they had fairly consistent carers and changes to the team were inevitable due to staff sickness or leave. Two people told us they would have preferred a more regular staff team. One person said, "The service is good when you get the same carers, but not when carers are swapped, but this is settling down now. I contact the office and they have tried to improve things by providing the same carers."

We reviewed four care plans. Each care plan recorded basic contact information as well as a personal profile and 'things important to me' section. The care plans also included very detailed and person-centred information about the support required at each visit. Care plans contained information in areas such as communication, hygiene, mobility, nutrition and fluids, sleep and rest, skin integrity, emotional wellbeing, pain, social inclusion and mental health. All care plans we reviewed were up to date and contained the outcomes people wished to achieve.

The Accessible Information Standard requires the service to ask, record, flag and share information about people's communication needs and take steps to ensure that these needs are met. We found detailed information regarding people's communication needs recorded in care plans to enable staff to involve people in their care, make choices and deliver person centred care. For example, to stand in front of a person who had a hearing impairment when speaking, as well as using visual clues, such as a sponge, when gaining consent to deliver personal care. Where one person used assistive technology to communicate, the care plan contained detailed instructions for staff to support good communication. Staff told us how they used a variety of methods to communicate with people according to their needs.

People and relatives told us they would feel comfortable raising issues and concerns with any of the staff or the managers and they knew how to complain. One person said, "I am happy to talk to the manager if things are not right, and when I have done this, things have changed."

The service had a complaints procedure which was included in the person's contract agreement when they started using the service. We saw, where complaints had been made, the manager had taken timely and appropriate action to resolve them.

People's wishes regarding end of life care were recorded where people wished to do so, and staff had received training in end of life care. The manager showed us a recent short-term care plan for one person, which had been put in place to enable them to be discharged from hospital and supported at home at the end of their life in line with their wishes. This contained the necessary basic information to enable care to be provided at short notice. Some people had a Do Not Attempt Resuscitation (DNAR) in place and a copy of this was kept in their care plan. The manager told us some people did not wish to discuss their end of life plans, however they intended to add a section to their long-term care plan to record this if required.

Good

Is the service well-led?

Our findings

People told us they thought the service was well managed and they were generally happy with the service provided. One person told us they could not recall anyone asking them about the service, but they did feel listened to by the care staff.

Four out of five care staff spoke positively about the management of the service and all staff told us the management team acted on any concerns. One staff member said the office staff rang them regularly for welfare checks to make sure they were happy with their work.

The manager had been in post at the service since May 2018 and they had applied to register with CQC, however the application had not yet been finalised. They were knowledgeable about people's individual needs and spoke with professionalism throughout the inspection.

We found there was an open culture with a desire to improve systems and to provide person centred care. The manager told us their aim for the service was, "To offer the best quality of safe care that we possibly can. We want employees to be settled and to provide a happy work environment." The care coordinator told us the company motto was, "Excellence in all we do."

The management team monitored staff compliance with the registered provider's procedures. They completed initial observations of staff practice and the manager told us they planned to follow this up annually. We saw audits were completed on people's daily records and MARs when they had been returned to the office. The manager told us they aimed to audit fifty percent of daily records and MARs each month if possible, however this had not all been completed due to staff vacancies in the office. The management team were catching up with these audits, checking the most recent first to ensure any current issues were addressed. We saw issues identified had been followed up with staff.

Care plans we reviewed were up to date. We saw one person's care plan audit form had been completed in July 2018, however the action that had been identified had not been completed. This was followed up by the manager. The quality and safety lead told us they and the operations manager checked a sample of care plans on their visits to the office. They told us that now the branch was growing, and some care plans had been in place for a year, a more systematic audit of care plans by the manager would be implemented.

The manager told us they felt supported by the registered provider and received weekly visits from their operations manager as well as speaking with them most days.

The registered provider had systems in place to monitor and improve the quality and safety of the service. A monthly clinical governance meeting was held to oversee and analyse any themes from incidents, accidents, safeguarding issues and complaints that had occurred. A compliance matrix was sent to the manager regularly by the registered provider to flag any shortfalls in completion of training, supervision or other management issues. Any new company initiatives and good practice guidelines from nationally recognised bodies, such as NICE, were also discussed and shared at the clinical governance meeting, which

included a representative from each branch.

People who used the service and their representatives were asked for their views about the service and they were acted on. A survey of people, or their relatives, had been conducted at intervals and the results were mostly positive. Any feedback was discussed at staff meetings.

We saw staff meetings had been held to discuss topics such as staff rotas, application of creams, medicines, safeguarding, reflective practice, confidentiality and staff training. Staff meetings are an important part of a registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care.

Positive feedback was sent to some staff in the form of a thank you postcard for good work. The registered provider held staff award ceremonies, where they felt staff had completed excellent work with people, to encourage and motivate staff with positive care practice. These systems demonstrated the service had effective quality assurance and governance processes in place to drive continuous improvement.

The manager told us they kept up to date with good practice by attending training, managers meetings and good practice events such as the local authority Home Care Providers forum. They told us they had completed nationally recognised health and social care qualifications at level five and were looking into higher level qualifications.

The management team worked in partnership with community health professionals to meet people's needs and drive up the quality of the service. We found there was never any delay in involving partners, such as social work and health teams, to ensure the wellbeing of people using the service.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. The inspection confirmed the registered provider was aware of their responsibilities to notify CQC and they had acted in accordance with the regulations.